Your
Guide to

Managed Care in Massachusetts

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Commonwealth of Massachusetts

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About this Guide

Massachusetts Residents,

Different sections of *Your Guide to Managed Care in Massachusetts* will be of interest to different people. Clicking on a topic in the table of contents will take you directly to that section.

The Massachusetts Division of Health Care Finance and Policy (DHCFP) and the Massachusetts Office of Patient Protection (OPP) are pleased to provide you with the fifth annual edition of *Your Guide to Managed Care in Massachusetts*.

The purpose of this guide is to give you information that will help you:

- Learn the differences between different types of health insurance and how those differences affect you,
- Choose a health plan that best meets your needs,
- File an appeal or complaint with your health plan if the need arises, and
- Find additional information on health plans.

This guide presents information, for comparison purposes, of ten commercial health plans that are licensed to operate in Massachusetts. Health plans offered by Medicare, MassHealth/Medicaid, and self-funded/ERISA plans are not covered here. Please see the "Additional Resources" section on page 33 for contact information to find out more about plans not covered in this Guide.

The information that compares health plans' performance is based on the most objective sources possible and organized into the following areas:

- Living and Staying Healthy
- Women's Health
- Child and Adolescent Health
- Diabetes Care
- Mental and Behavioral Health
- Members' Satisfaction Ratings of their Health Plan

Quality Matters

The quality of health care you receive is determined by both the doctors you see and your health plan. The highly respected Institute of Medicine (within the National Academy of Sciences) agrees, reporting that quality in our health care system varies greatly by many factors, including which hospital or doctor you choose.[1]

Since *Your Guide to Managed Care in Massachusetts* distinguishes quality of care by health plan only, it is important to keep in mind that many differences in quality that are seen in the following health indicators may be beyond the control of the health plan administrators.

For information on hospitals, please visit the Commonwealth's newly launched website: www.mass.gov/healthcareqc. This website allows you to compare both quality and cost information for different health care procedures performed by different hospitals and doctors in Massachusetts. It is among the first in the country to compare hospitals by their quality of care and the payments that hospitals receive for selected procedures.

Quality Indicators

The quality indicators listed in *Your Guide to Managed Care in Massachusetts* come from the National Committee for Quality Assurance's (NCQA's) 2005 Quality Compass® database, which includes quality data from the Health Plan Employer Data and Information Set (HEDIS®) and member satisfaction data from the CAHPS survey. This Guide does not present the complete list of indicators available. For more information from NCQA, please visit their website at www.ncqa.org.

The quality indicators presented in *Your Guide to Managed Care in Massachusetts*:

- are the most likely to be of interest to the largest number of health plan members in Massachusetts, and
- showed the greatest difference in quality performance among the plans.

Health Plans, Managed Care, and You

"Managed care" is often used to describe health plans that make use of networks of doctors, hospitals and other health care providers (i.e., nurses, midwives, etc.) or that use utilization review in making decisions about whether services are covered benefits. *Your Guide to Managed Care in Massachusetts* is designed to give you basic facts about managed care and tells you where to go for additional information.

Your Guide to Managed Care in Massachusetts does not address all of the questions that you may have about selecting a health plan. Contact information for the licensed health plans in Massachusetts, Medicare, MassHealth/Medicaid, and other programs is included in the "Additional Resources" section so that you can contact the proper organization with your questions.

Types of Health Plans

Your Guide to Managed Care in Massachusetts provides you with a basic overview of the most popular types of health plans currently available. For more complete information on a health plan, review your "evidence of coverage" (health plan policy) or contact the health plan directly. For group health plans, your human resources department should be able to provide you with information about the specific plan or plans offered by your employer.

Generally, the most popular types of health plans are:

- health maintenance organizations (HMOs)
- point of service (POS) plans
- preferred provider organizations (PPOs)
- indemnity or fee-for-service plans

High Deductible Health Plans (HDHP)

In addition, there has been a growing trend to give consumers more control and responsibility in managing their own care and high deductible health plans (HDHP) are an example of this trend. HDHPs carry both high risks and savings opportunities. Although HDHPs are not yet widely offered, some experts predict that these products will grow in popularity.

Anyone enrolled in a high deductible health plan (HDHP) must also have a health savings account (HSA) which is discussed in more detail later. HDHPs require you to pay a higher deductible each year than that of most other health plans. For 2006, the minimum deductible amount for an HDHP is $1,050 for individual coverage and $2,100 for family coverage.[2] Money from your HSA can be used to pay for part or all of your deductible.

HDHPs also have a maximum limit on the total out-of-pocket amount you pay each year. The 2006 maximum limit for out-of-pocket expenses is $5,250 for individual coverage and $10,500 for family coverage.[3] Out-of-pocket expenses include deductibles, copayments, and other medical expenses you pay for qualified medical care, but do not include plan premiums.

Since HSAs and HDHPs are new creations and constantly changing, there is no general model of an HDHP. Some HDHPs offer coverage for primary care visits and important screening procedures, others do not.[4] Some plans negotiate discounts for certain health

services, others do not. Make sure you carefully read the HDHP benefits manual before selecting an HDHP.

Having an HSA gives you more freedom to, and responsibility for, managing your health care. Unlike HMOs, PPOs, or POS plans, whose monthly premiums generally provide "first dollar coverage" with minimal copayments and often no deductibles, HDHPs require you to pay for your own health services either "out of pocket" or through the HSA until you have met your deductible. HDHPs involve some personal risk and are not for everyone.

For some people, good savings practices may make HDHPs a good plan for you and your family. If you choose to enroll in an HDHP, be sure to take into account the financial impact of an unforeseen health care crisis on you and your family.

General Differences among Popular Managed Care Plans

In today's environment, there are fewer differences among managed health plans than in the past. Ever since managed care became popular in the 1980s, consumers have pushed for more freedom, choice, and variety within their health plans In response to this consumer demand, insurers created new products that allowed more freedom of choice by allowing patients to self-refer or use out-of-network providers for an additional cost.

Additionally, many doctors in Massachusetts participate in multiple insurance networks thus making it easier for members to change insurance companies without changing doctors.

Table 1 (below) compares HMO, POS, PPO, and traditional fee-for-service (or indemnity) plans to help you better understand health plans in general. Since the information provided in Table 1 is based on a basic model of what these plans are, your actual health plan may have different characteristics from those listed. Please refer to your plan benefits package for a more accurate description of your health plan and what it covers.

Table 1: Comparison of Popular Health Plan Types

HMO[1]	POS[2]	PPO	Indemnity[3]
Who can I see for care?			
Your plan's network of doctors, hospitals, specialists, and other health care providers.	In-network or out-of-network providers. But, if you go out of network, you will have to pay more for your care.	In-network or out-of-network providers. But, if you go out of network, you will have to pay more for your care.	Any health care provider that accepts your plan.
Do I need to designate a primary care physician (PCP)?			
Yes. Your PCP helps manage and coordinate all your health care needs.	Yes. Your PCP helps manage and coordinate all your health care needs.	No. You can see any physician you want.	No. You can see any physician you want.

Health Plans, Managed Care, and You

HMO[1]	POS[2]	PPO	Indemnity[3]
How do I pay for services?			
You pay a copayment for most or all health care services. There is usually no need to fill out a claim form. You might also have a deductible or coinsurance for some services.	For in-network providers, you may pay a copayment or coinsurance for any service you use and you may have a deductible. There is usually no need to fill out a claim form For out-of-network providers, you may pay a higher copayment or coinsurance and may have a higher deductible than for in-network services. Members may also have to fill out a claim form.	For in-network providers, you may pay a copayment or coinsurance for any service you use and you may have a deductible. There is usually no need to fill out a claim form. For out-of-network providers, you may pay a higher copayment or coinsurance and may have a higher deductible than for for in-network services. Members may also have to fill out a claim form.	You pay a deductible and coinsurance. Members fill out a claim form.
Do I need a referral from my PCP to see a specialist?			
Yes, usually for most visits to specialists.	Yes, usually for most in-network specialists. Not usually needed for out-of-network providers.	Referrals are usually not needed to see any provider.	Referrals are usually not needed to see any provider.
Who pays if I see a provider outside of my network?			
Usually, you pay for care outside of the network out of your own pocket. Plan may pay for emergency care provided by out-of-network providers.	You pay more for care than you would if you had gone to an in-network provider unless you receive emergency care.	You pay more for care than you would if you had gone to an in-network provider unless you receive emergency care.	The same rules apply to all providers.

What happens if I change jobs[4]?

Your employer-based health care coverage does not continue if you change jobs. If, for some reason, you do not have insurance coverage after you leave your job (e.g., your new employer does not offer health insurance, your new employer has a waiting period in order to qualify for insurance, or you are unemployed), you can usually continue your health plan coverage with your former employer for at least 18 months. However, continuation of health care coverage usually comes at a much higher cost to you.

- Employees who have lost their health insurance and were covered by an employer health plan in a firm that employed 20 or more employees can qualify for federal COBRA continuation coverage. For more detailed rules and regulations on COBRA, please visit www.dol.gov/ebsa.[5]
- For groups with between 2-19 eligible employees, state law (M.G.L. c. 176J §9) provides similar continuation rights. Please review your policy or contact your health carrier for more information.

Health Plans, Managed Care, and You

Health Care Savings Accounts

Currently, there are up to four types of accounts that your employer or you (if you are self-employed) may establish that offer you tax benefits on certain health care costs. These include:

Flexible Spending Arrangements (FSA): the most common account (offered by 35% of employers), allows pre-tax money to be saved for health care services that are not covered by your health insurance.

Health Savings Accounts (HSA): a new (and still uncommon account) that must be paired with a high deductible (but a lower premium) health plan that increases both your risk for incurring high health care costs and your opportunity to save on health insurance premiums.

Medical Savings Accounts (MSA): a variation of an HSA for the self-employed or small employers.

Health Reimbursement Arrangements (HRA): a variation of an FSA in which only the employer contributes to the account.

The money in these accounts can be used for various "qualified medical expenses" that your insurance doesn't cover. Qualified medical expenses include doctor's fees, prescription medications, over-the-counter medications, and necessary hospital services not covered by insurance. For a complete list of qualified medical expenses, please see the IRS's Publication 502 at www.irs.gov/publications/p502/index.html.

In these accounts, the money can be either tax-deductible (HSA and MSA) or taken out of your pre-tax earnings (FSA and HRA). The money taken out and spent on qualified medical expenses is not taxed either. Interest earned in health savings accounts and medical savings accounts is also not taxed.

These accounts are complicated and are governed by many federal rules, regulations, and limits that are not discussed in this guide. For details regarding any of the information provided in this section, please visit the Internal Revenue Service (IRS) website at www.irs.gov.

Table 2 (on page 9) provides a very general overview of the differences among the four tax-favored accounts used to pay for health care costs.

Table 2: Comparison of Tax-Favored Accounts for Health Care Costs

FSA[1]	HSA[2]	Archer MSA[3]	HRA[4]
You are eligible if you…			
Work for an employer that offers you a FSA and are not self-employed.	Are enrolled in high deductible health plan (HDHP), not covered by Medicare or any health coverage that is not permitted, and not listed as anyone else's dependant for tax purposes.	Are self-employed or work for a small employer and enrolled in a non-Medicare HDHP.	Work for an employer that offers you a HRA and are not self-employed.
Who can contribute to the account?			
You and/or your employer contribute.	You (even if you are self-employed or unemployed), your employer, your family members, and/or anyone who wants to contribute to your HSA.	You OR your employer contributes.	ONLY your employer contributes.
How much can I contribute?			
Maximum allowable contribution set by the IRS and your employer.	Depends on your HDHP coverage and your age.	Depends on your HDHP deductible and your income.	Maximum reimbursement set by your employer.
What is the money used for?			
ONLY qualified medical expenses not covered by your health plan.	Medical expenses not covered by your HDHP (including those counting towards your deductible), qualified medical expenses, and premiums for long-term care coverage, health coverage while unemployed, health continuation coverage.	Medical expenses not covered by your HDHP (including those counting towards your deductible), qualified medical expenses, and premiums for long-term care coverage, health coverage while unemployed, health continuation coverage.	Qualified medical expenses, health insurance premiums, long-term care coverage, amounts not covered under another health plan.
What happens if I do not use up all the money at the end of the year?			
You lose any unused portion of your FSA at the end of the year. Your FSA does not follow you if you change jobs.	Nothing. It stays with you even if you leave the workforce or change jobs.	Nothing. It stays with you even if you leave the workforce or change jobs.	Unused money in your HRA carries over to the next year. Your HRA does not follow you if you change jobs.

Health Plans, Managed Care, and You

Fraudulent Plans

Not all health insurance plans that are sold are legal. Some may be legal in other states, but are not licensed in Massachusetts.

If you are self-employed, or are a small employer seeking to provide medical benefits, you should check with the Division of Insurance's (DOI) Consumer Service at (617) 521-7777, or visit the DOI website at www.mass.gov/doi/Managed_Care/managed_care_home.html to make sure that the plan you are being offered can legally be sold in Massachusetts.

Illegal plans do not have the protections of guaranty funds, and may leave you and your employer with unpaid bills. Such plans often require joining a (non-existent) union or a "merchant" or "professional" association which cannot offer health insurance or benefits under state or federal laws.

Choosing a Health Plan

Choosing a health plan that meets the unique needs of you and/or your family is your responsibility. There is no one plan that will fit everybody's needs at the same time. Thus, consumers need to decide for themselves which plan is best for them.

Important things to consider when selecting a health plan are:

- Employer offerings: many employers only offer one plan
- The quality of care and service you will receive
- Whether you will be able to see the doctor you want
- Whether your special health care needs are covered
- The overall cost of the plan for you and your family

Quality of Care and Service

There are a variety of services and protections available to help you choose a health plan that offers the level of care you and your family need. In addition to the resources described in the "Quality Matters" section, you can also look to see if your health plan is licensed to operate in Massachusetts and accredited by a reputable organization.

Accreditation by the Massachusetts Bureau of Managed Care

Since 2001, the Bureau of Managed Care within the Division of Insurance (DOI) has set minimum standards for managed care organizations and investigates complaints against a carrier for noncompliance with accreditation requirements.

Under Massachusetts law, managed care organizations must be accredited by the Bureau in order to offer managed care plans in Massachusetts. Managed care organizations are required to let the Bureau know what systems are in place to manage care, and detect problems and correct them.

However, not all plans are subject to Massachusetts law. For example, self-funded/ERISA plans, Medicare, and MassHealth/Medicaid plans, the Group Insurance Commission self-funded plans, and the Federal Employees Plan are exempt from state insurance laws.

Accreditation by Private Accrediting Organizations

Another way to consider the quality of a health plan is to find out whether or not it is accredited by a private accrediting organization. The value of accreditation varies by what is required to become accredited and how dependable the system is. The NCQA and the American Accreditation Healthcare Commission/Utilization Review Accreditation Commission (URAC) are two organizations that accredit health plans.

Table 3 on pages 12-13 shows the National Committee for Quality Assurance (NCQA) accreditation status for the health plans that sought NCQA accreditation.

Choosing a Health Plan

Table 3: Massachusetts Health Plan Profiles

Health Plan	Telephone/TTY Website	Number of Members (combined HMO/POS)*	Massachusetts Counties Served**
Aetna Health Inc. 400-1 Totten Pond Road Waltham, MA 02451	(800) 872-3862 (800) 842-9710 www.aetna.com	22,660	All counties except Dukes and Nantucket
Blue Cross and Blue Shield of Massachusetts Landmark Center, 401 Park Drive Boston, MA 02215-3326	(800) 262-BLUE (2583) (800) 522-1254 www.bluecrossma.com	1,230,000	All counties except Dukes
CIGNA Healthcare of Massachusetts, Inc. 100 Front Street, Suite 300 Worcester, MA 01608-1449	(800) 345-9458 (800) 654-5988 www.cigna.com	107,651	All counties except Dukes and Nantucket
ConnectiCare of Massachusetts Inc. 175 Scott Swamp Road, P.O. Box 4050 Farmington, CT 06034-4050	(800) 846-8578 (800) 833-8134 www.connecticare.com	15,073	Only Franklin, Hampden, and Hampshire counties
Fallon Community Health Plan 10 Chestnut Street Worcester, MA 01608-2810	(800) 868-5200 (877) 608-7677 www.fchp.org	134,693	All except Barnstable, Berkshire, Dukes, Nantucket, and parts of Bristol, Franklin, Hampden, Hampshire, and Plymouth
Harvard Pilgrim Healthcare, Inc. 93 Worcester Street Wellesley, MA 02481-9181	(888) 333-4742 (800) 637-8257 www.harvardpilgrim.org	674,428	All counties except Nantucket
Health New England, Inc. One Monarch Place, Suite 1500 Springfield, MA 01144	(800) 310-2835 Use relay service www.hne.com	70,614	Only counties of Berkshire, Franklin, Hampden, Hampshire, and parts of Worcester
Neighborhood Health Plan 253 Summer Street Boston, MA 02210	(800) 462-5449 (800) 655-1761 www.nhp.org	25,222	All counties except Barnstable, Dukes, Franklin, Hampshire, Nantucket, and parts of Bristol and Plymouth
Tufts Health Plan 333 Wyman Street, PO Box 9112 Waltham, MA 02454-9112	(800) 462-0224 (800) 815-8580 www.tuftshealthplan.com	581,436	All counties except Dukes and Nantucket
UnitedHealthcare of New England, Inc. 475 Kilvert Street, Suite 310 Warwick, RI 02886-1392	(800) 410-3385 (888) 685-8480 www.unitedhealthcare.com	132,612	All counties except Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket

* NCQA Quality Compass. Washington, DC: NCQA, 2005. Accessed 3 Nov. 2005. <http://www.qualitycompass.org>

** "HMO Carrier Service Area by Massachusetts County." Boston: Massachusetts Bureau of Managed Care, Division of Insurance. Accessed 3 Nov. 2005. <http://www.mass.gov/doi/Consumer/HMO/HMO_Service.pdf>

*** "NCQA Health Plan Report Card: Commercial, MA." Washington, DC: NCQA, 2005. Accessed 3 Nov. 2005. <http://hprc.ncqa.org/frameset.asp>

Note: If you have questions about the legitimacy of a health plan you are considering purchasing, contact the Massachusetts Division of Insurance–see Additional Resources for more information.

Choosing a Health Plan

NCQA Accredited***	Accreditation Status***	Accreditation Report Card Categories (5 stars is best)				
		Access & Service***	Qualified Providers***	Staying Healthy***	Getting Better***	Living with Illness***
✔	Excellent	★★★★	★★★★	★★★★	★★★★	★★★★
✔	Excellent	★★★★	★★★★	★★★★	★★★★	★★★★
✔	Excellent	★★★★	★★★★	★★★★	★★★★	★★★★
✔	Excellent	★★★★	★★★★	★★★★	★★★★	★★★★
✔	Excellent	★★★★	★★★★	★★★★	★★★★	★★★★
✔	Excellent	★★★★	★★★★	★★★★	★★	★★★★
✔	Excellent	★★★	★★★★	★★★★	★★★★	★★★★
Not Accredited by NCQA						
✔	Excellent	★★★★	★★★★	★★★★	★★★★	★★★★
✔	Excellent	★★★★	★★★	★★★★	★★★★	★★★★

Choosing a Health Plan

Provider Choice

Make sure that the doctors, clinics, and hospitals you prefer are within your health plan network. This information can be found by asking your health care provider, by looking at the health plan's directory, website, or by calling the health plan's customer service. The "Additional Resources" section (pages 33-34) lists contact information for all licensed health plans in Massachusetts.

Health Benefits

When selecting a health plan, it is important to review the benefits that are offered and to make sure that your selected plan covers the care that you and your family anticipate using. For example, if you take a lot of prescription medications you can review a health plan's formulary (list of medications it covers and at what copayment) to determine your approximate costs and which health plan may be best for you.

Plan Costs

Although cost should not be the only factor used in deciding a health plan, it is, nevertheless, an important one. Whether you pay directly for coverage or through a deduction from your salary, you should look at the costs you will have when using the plan and focus on:

- Premiums
- Your deductible amount (if applicable) for care
- Copayments or coinsurance for visits to the doctor, specialists, necessary treatments and procedures, prescriptions, and any other regular or anticipated health care needs
- Costs of emergency room visits, care when you travel outside of your coverage area, care that you obtain outside of your network of providers

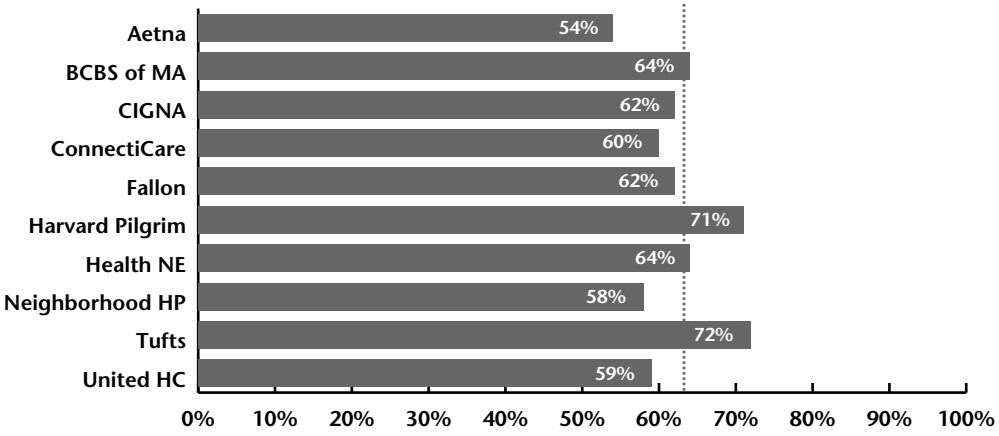
Make sure you consider the entire cost of getting care that you need through a health plan before choosing one. Knowing what you and your family spend on average on health care is crucial to selecting the right health plan. Keeping track of your health care costs is especially important if you are enrolled in a health savings account (HSA) or medical savings account (MSA) with a high-deductible health plan (HDHP). If you are enrolled in a HDHP, it is also important to save enough in your HSA/MSA to cover your maximum deductible amount in case you or your family has an expensive medical emergency.

Generally, plans with lower premiums are associated with higher office visit copayments, deductibles, and/or other out-of-pocket costs for which you may be responsible. When combined together, these costs may outweigh the savings you have gained from selecting a plan with a lower premium.

Living Healthy and Staying Healthy

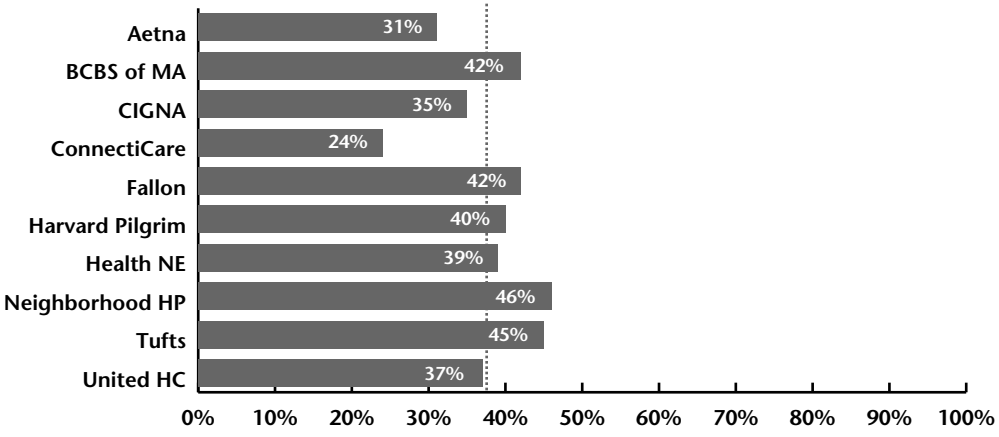
Your health plan and your health care provider work hard to keep you strong and healthy. Taking steps to preserve your health will allow you to enjoy an active, full, and happy life. For the indicators listed, the *higher* the percentage, the *better* the plan performance. The dotted line indicates the average of all health plans for that indicator.

Figure 1: Testing for Colorectal Cancer



Colorectal cancer is the 3rd most common form of cancer among men and women.[14] Research shows that the regular screening and removal of abnormal growths (polyps) may prevent cancer development.[15] Figure 1 shows the percentage of adults ages 50 to 80 who were given an appropriate test to screen for colorectal cancer.

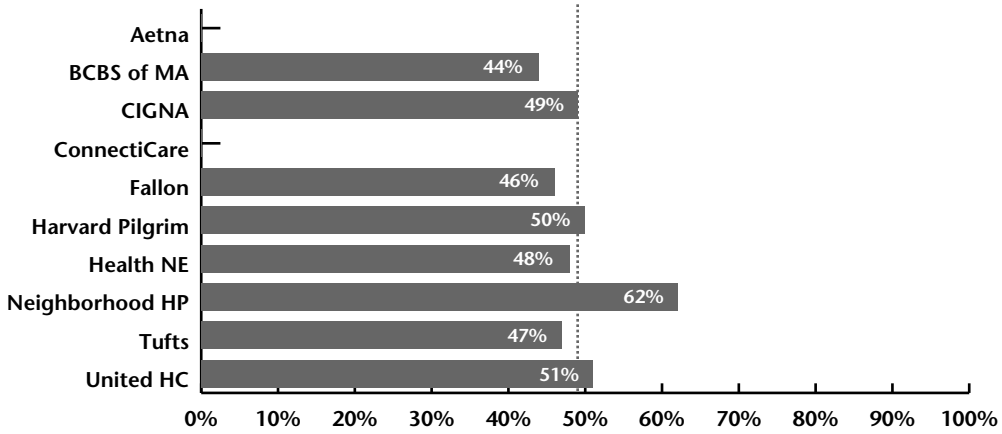
Figure 2: Flu Shots



The flu may cause a range of health problems ranging from fever and body aches to pneumonia.[16] Getting a flu shot may reduce the likeliness of getting the flu or make flu symptoms less severe for those who do.[17] Figure 2 shows the percentage of adults ages 50 to 64 who received a flu shot.

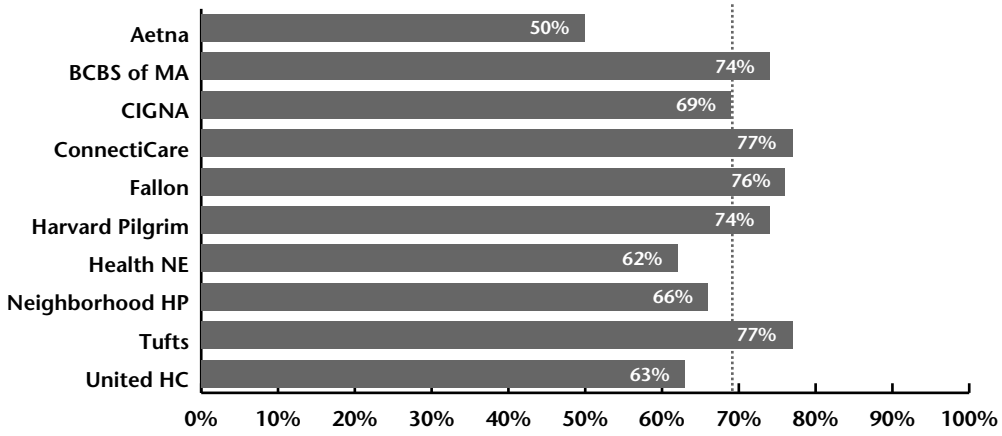
Living Healthy and Staying Healthy

Figure 3: Discussion of Ways to Stop Smoking



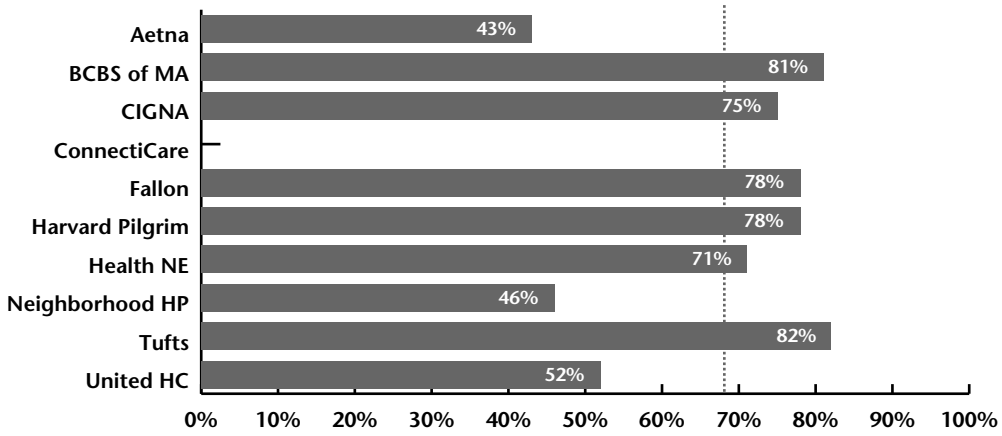
Lung cancer kills more men and women in America than any other cancer.[18] People who quit smoking can greatly reduce their risk of getting lung cancer. Figure 3 shows the percentage of adult smokers who received advice from a health provider on ways to stop smoking.

Figure 4: Controlling High Blood Pressure



High blood pressure affects nearly 1 in 3 American adults.[19] High blood pressure can damage blood vessels and lead to stroke, heart attack, kidney failure, and vision problems.[20] Figure 4 shows the percentage of adults ages 46 to 85 who have high blood pressure and are able to keep it under control.

Figure 5: Managing Cholesterol

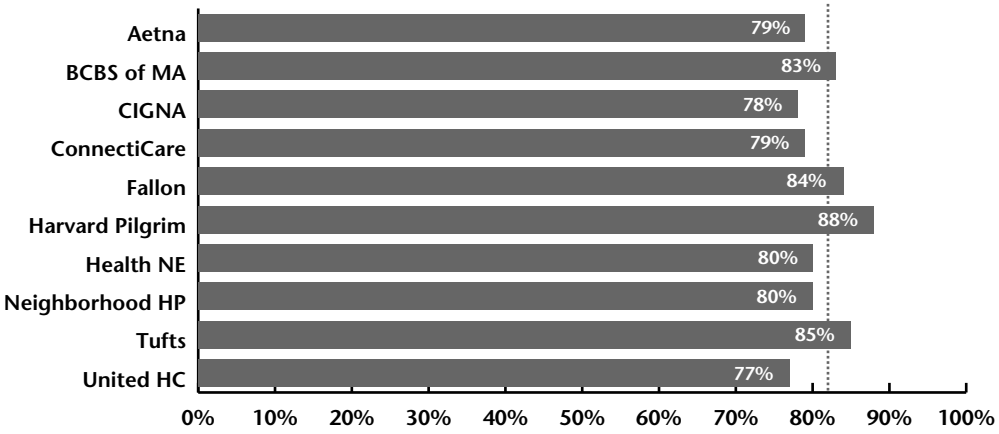


Lowering cholesterol levels may reduce the chances of developing heart disease and having a heart attack.[21] Figure 5 shows the percentage of adults ages 18 to 75 who have been hospitalized for major heart issues and were able to keep their "bad" cholesterol level (LDL-C) below 130 mg/dL up to a year after being discharged.

Women's Health

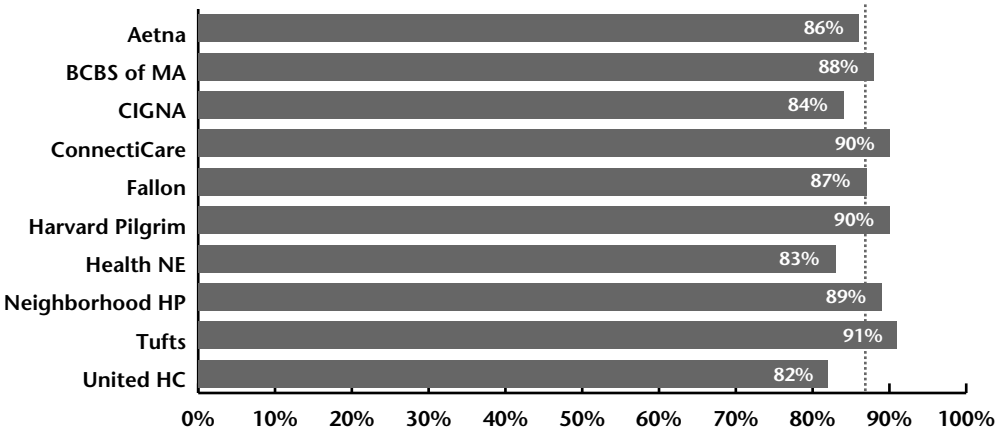
Women have many special health care needs and concerns. Making sure that you and/or the women in your life receive the proper care and screening is an important responsibility. Higher percentages indicate better plan performance. The dotted line indicates the average of all health plans for that indicator.

Figure 6: Testing for Breast Cancer



Breast cancer kills over 40,000 people each year.[22] Women may be more likely to survive breast cancer if it is detected early by getting mammograms on a regular basis. Figure 6 shows the percentage of women ages 50 to 69 who received a mammogram within the past two years.

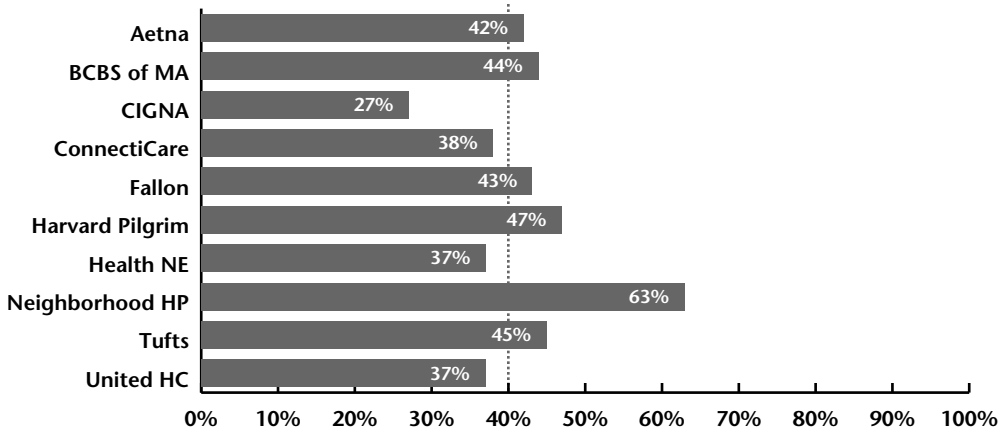
Figure 7: Testing for Cervical Cancer



When caught and treated early, the survival rate among women with cervical cancer is nearly 100%.[23] Getting regular Pap tests helps health care providers find and remove abnormal cells in their early stages. Figure 7 shows the percentage of women ages 18 to 64 who received a Pap test within that past three years.

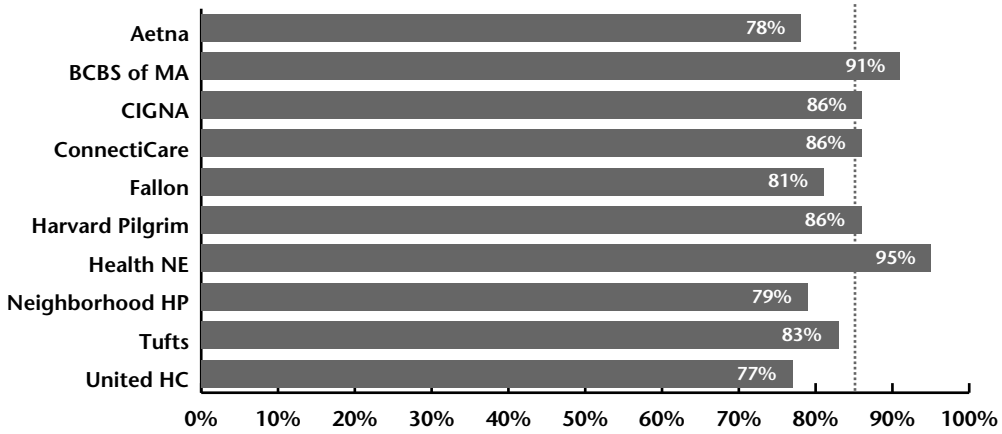
Women's Health

Figure 8: Testing for Chlamydia



Chlamydia is the most commonly reported sexually transmitted disease in the U.S.[24] Figure 8 shows the percentage of sexually active women ages 16 to 25 who were tested for Chlamydia.

Figure 9: Care Given to Women after Childbirth

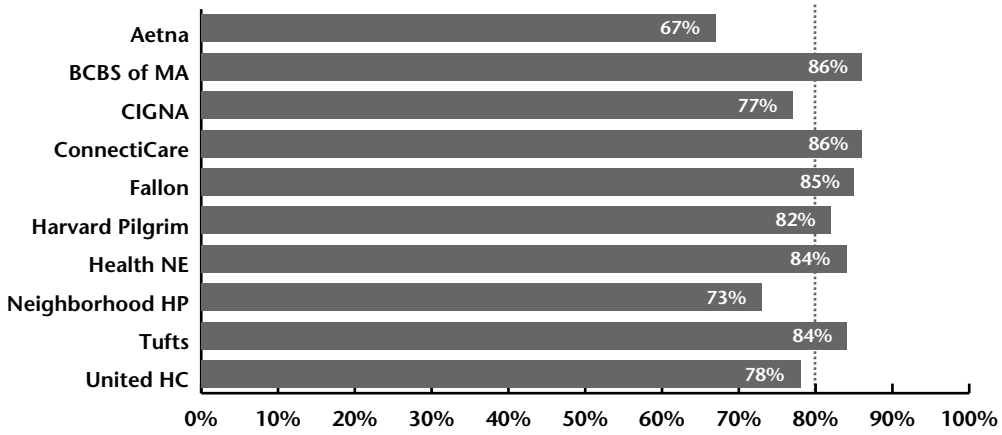


During a postpartum visit (a visit with a health care provider after the delivery of a child), doctors and nurses make sure the mother and child are doing well and answer any questions the new mother has.[25] Figure 9 shows the percentage of members who had a postpartum visit within three to eight weeks after giving birth.

Children's Health

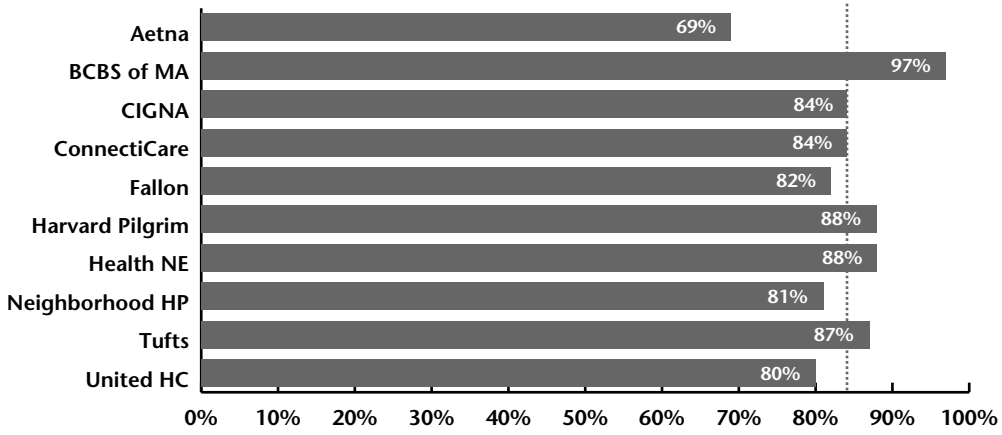
The health care needs of young children constantly change as they grow and develop. Keeping up with routine check-ups and preventive care can help your child be strong and healthy. The higher the indicator percentage, the better the plan's performance. The dotted line indicates the average of all health plans for that indicator.

Figure 10: Immunizations for Children



Immunizations prevent diseases in children. Figure 10 shows the percentage of children who received the recommended immunizations for diphtheria, whooping cough (pertussis), lockjaw (tetanus), polio, measles, mumps, rubella (German measles), hepatitis B, meningitis and pneumonia (HiB), and chicken pox[26] by age 2.

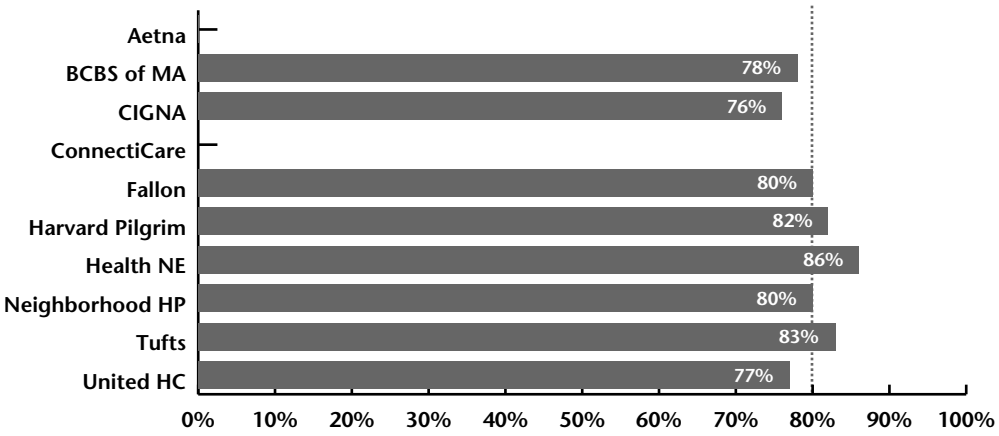
Figure 11: Routine Check-ups for Children



During a routine visit, the doctor can check on a child's overall health, behavior, growth, and development.[27] Doctors and nurses can also use this time to answer any questions the parents may have. Figure 11 shows the percentage of children who have had six or more well-child visits by the time they reach 15 months of age.

Children's Health

Figure 12: Good Treatment for Children with Asthma

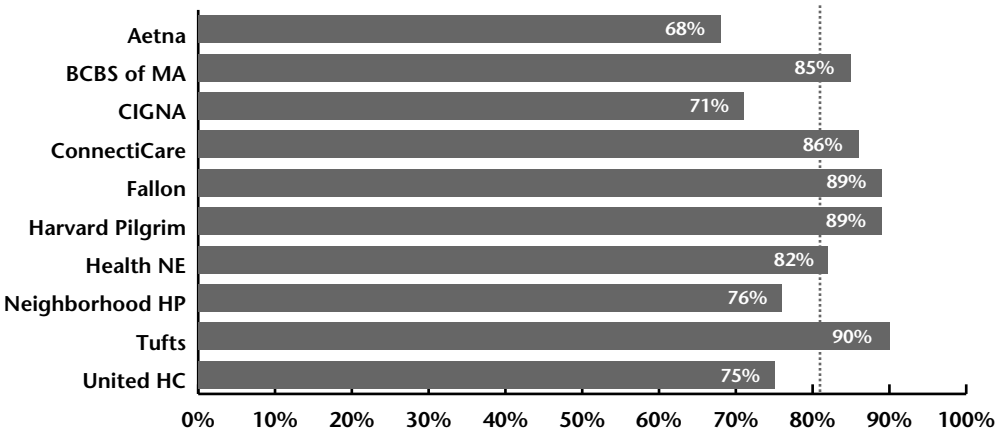


Proper treatment may help children with asthma lead healthy, active, normal lives. Gaining control of asthma may reduce visits to the emergency room[28] or hospitalizations. Figure 12 shows the percentage of members ages 5 to 9 who have asthma and are prescribed the proper medications for treatment.

Adolescent Health

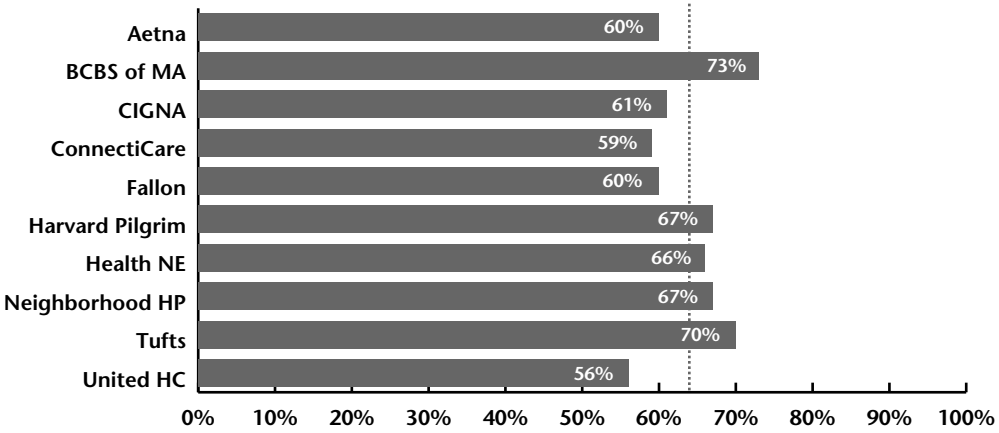
Teenagers have different health care needs than younger children. Making sure that your teenager has the right care while going through this stage of his or her life is an important responsibility.

Figure 13: Immunizations for Adolescents



Adolescents need to keep up with their immunizations and booster shots to make sure that they have continued protection from disease.[29] Figure 13 shows the percentage of adolescent members who received the recommended immunizations for diseases including measles, mumps, rubella, hepatitis B, and chicken pox by age 13.

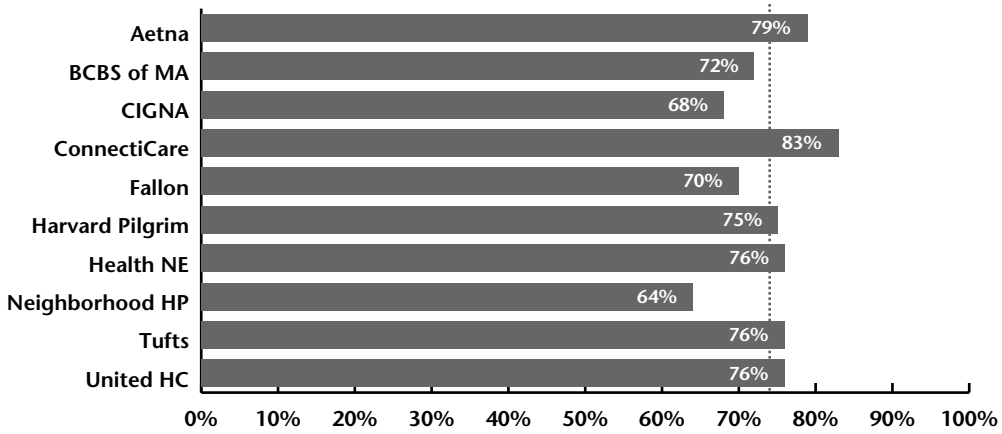
Figure 14: Routine Check-ups for Adolescents



During a routine well-care visit, health care providers can monitor a teenager's overall health, growth, and development.[30] Adolescents can also use this time to have their questions answered. Figure 14 shows the percentage of adolescent members ages 12 to 21 who have had at least one comprehensive well-care visit with a primary care or obstetrics/gynecology (OB/GYN) practitioner within the past year.

Adolescent Health

Figure 15: Good Treatment for Adolescents with Asthma

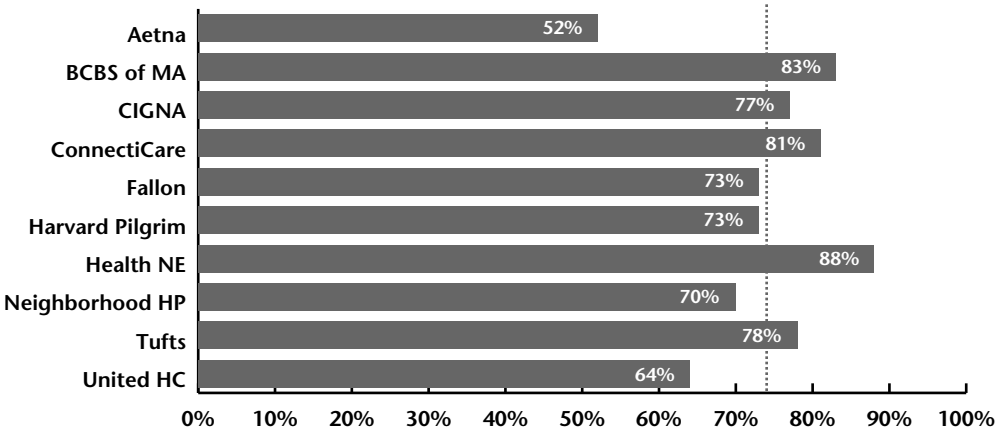


Proper treatment may help children and adoloescents with asthma lead healthy, active, normal lives. Gaining control of asthma may reduce visits to the emergency room[31] or hospitalizations.[32] Figure 15 shows the percentage of members ages 10 to 17 who have asthma and are prescribed the proper medications for treatment.

Diabetes Care

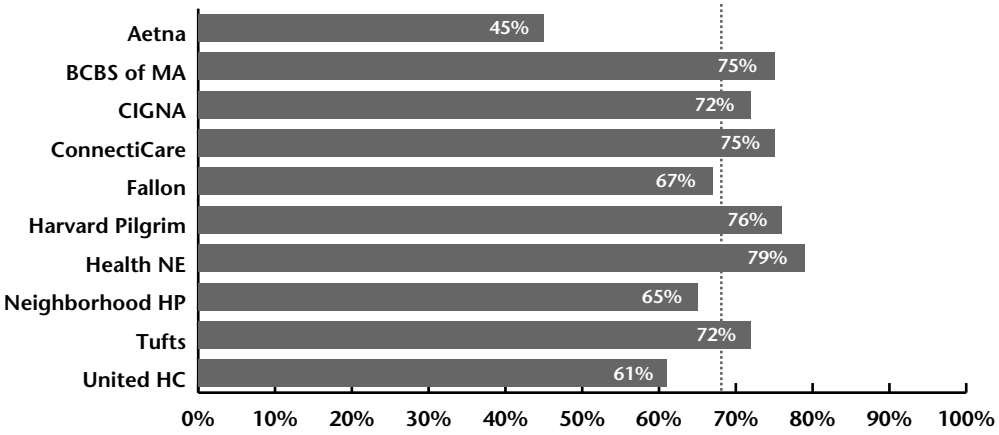
Diabetes is a serious illness that affects many Americans of all ages. Proper care and treatment of diabetes can reduce serious health problems that are associated with the disease. Higher percentages indicate better plan performance. The dotted line indicates the average of all health plans for that indicator.

Figure 16: Controlling Blood Sugar



Proper control of blood sugar (glucose) level can help prevent health complications from diabetes.[33] Figure 16 shows the percentage of members with diabetes who were able to keep their blood sugar (measured by hemoglobin A1c level) below 9.0%.

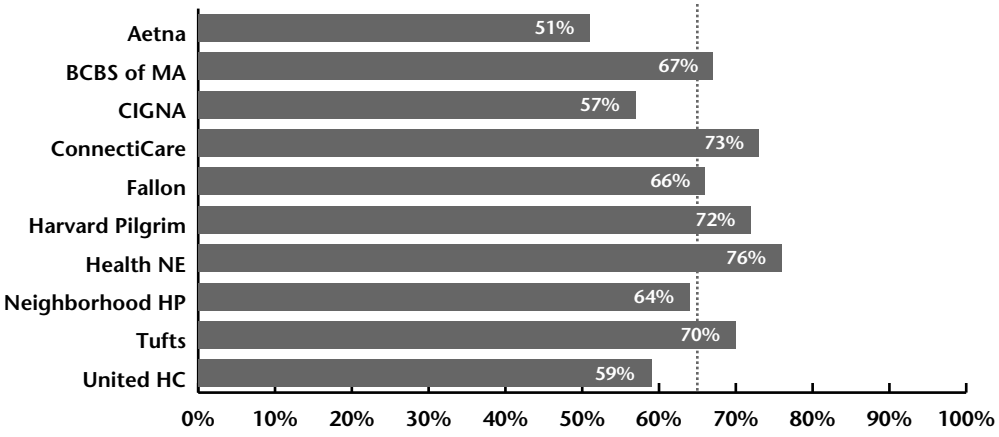
Figure 17: Controlling Cholesterol



Maintaining normal cholesterol levels is an important part of properly controlling and managing diabetes, and reducing the risk of heart disease.[34] Figure 17 shows the percentage of members with diabetes whose "bad" cholesterol (LDL-C) level was below 130 mg/dL.

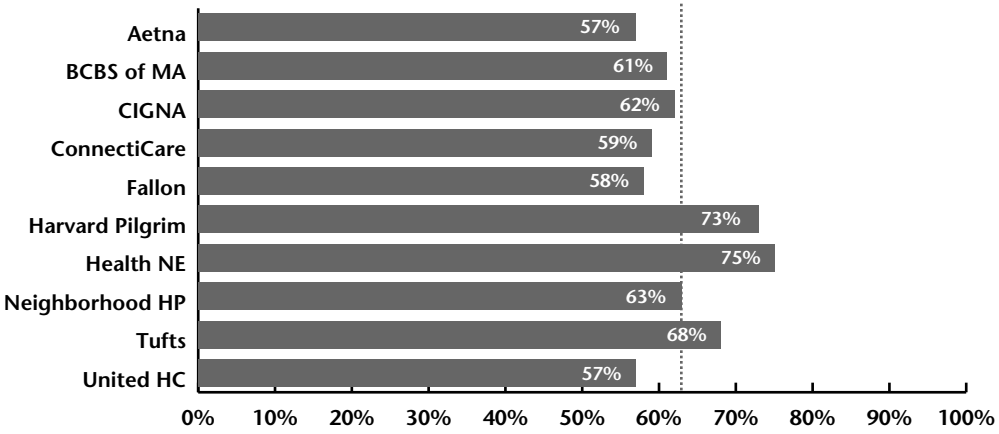
Diabetes Care

Figure 18: Monitoring for Eye Problems



Having a high level of blood sugar can lead to serious eye problems including early development of cataracts or irreversible blindness.[35] Regular eye exams can help reduce the risk associated with these problems.[36] Figure 18 shows the percentage of members with diabetes who were tested for eye problems.

Figure 19: Monitoring for Kidney Problems

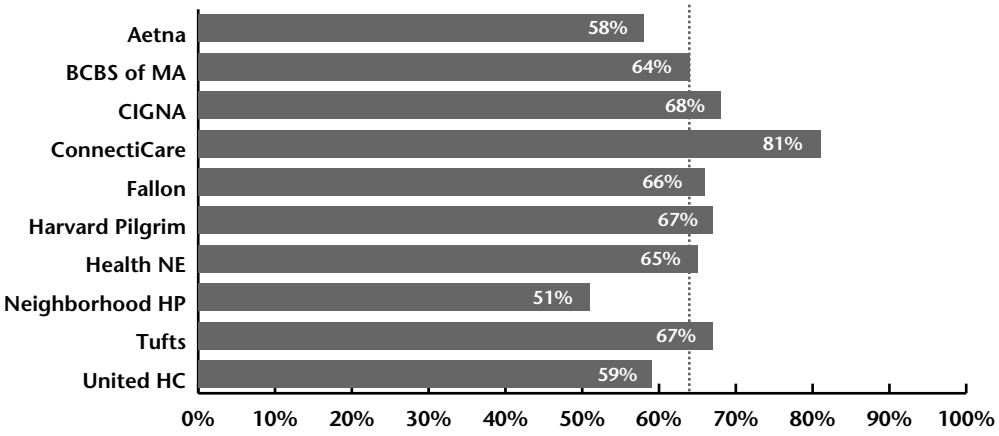


Almost one-third of people with diabetes develop kidney disease (diabetic nephropathy).[37] Regular testing for kidney problems reduces the risk of kidney failure. Figure 19 shows the percentage of members with diabetes who were tested for kidney disease (nephropathy).

Mental and Behavioral Health

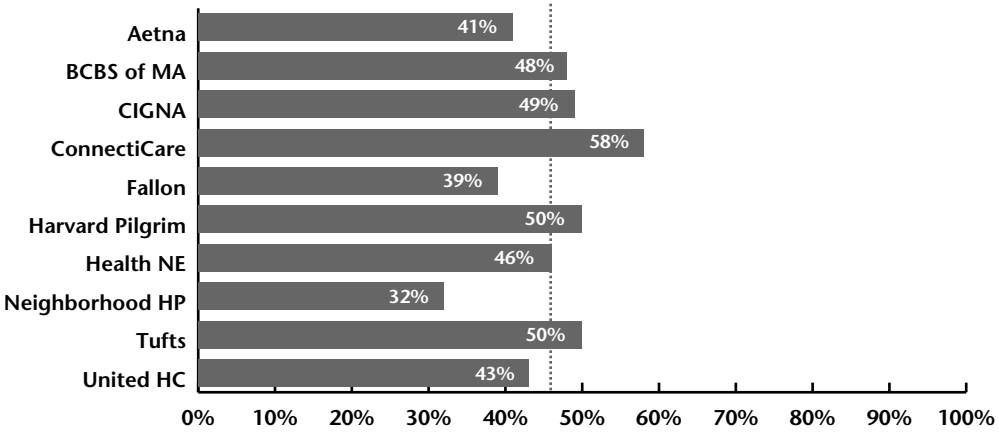
Almost 19 million American adults live with serious depression that can affect their work, family, and social life.[38] Having good mental and behavioral health is important to leading a healthy life. Higher indicator percentages indicate better plan performance. The dotted line indicates the average of all health plans for that indicator.

Figure 20: Good Antidepressant Medication Management – 3 Months



Antidepressants should be taken regularly for the first few months after being diagnosed with depression for the medication to be fully effective.[39] Figure 20 shows the percentage of patients who were treated with antidepressant medication that continued their medication for at least three months after being diagnosed with depression.

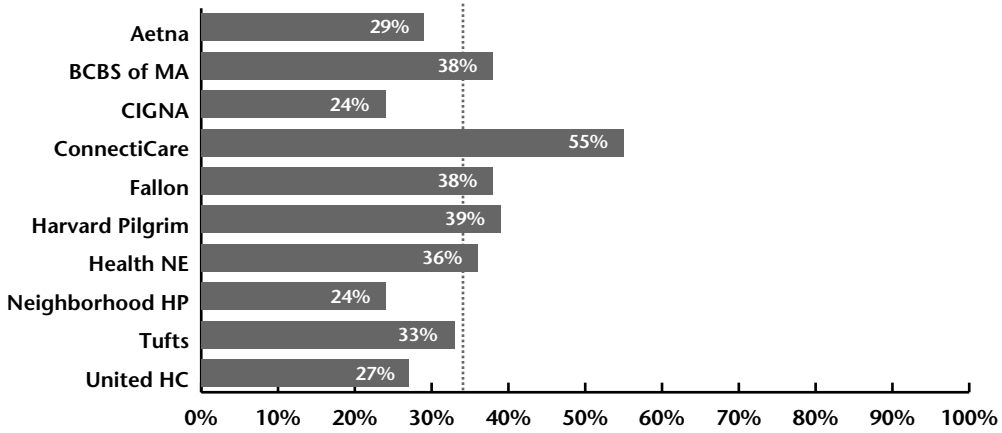
Figure 21: Good Contact with Health Care Provider



Regularly visiting your health care provider during the first few months of taking antidepressants helps ensure that the treatment is working and that there are no side effects.[40] Figure 21 shows the percentage of patients who were treated with antidepressant medication and saw their primary care physician or mental health practitioner at least three times within their first three months of being diagnosed with depression.

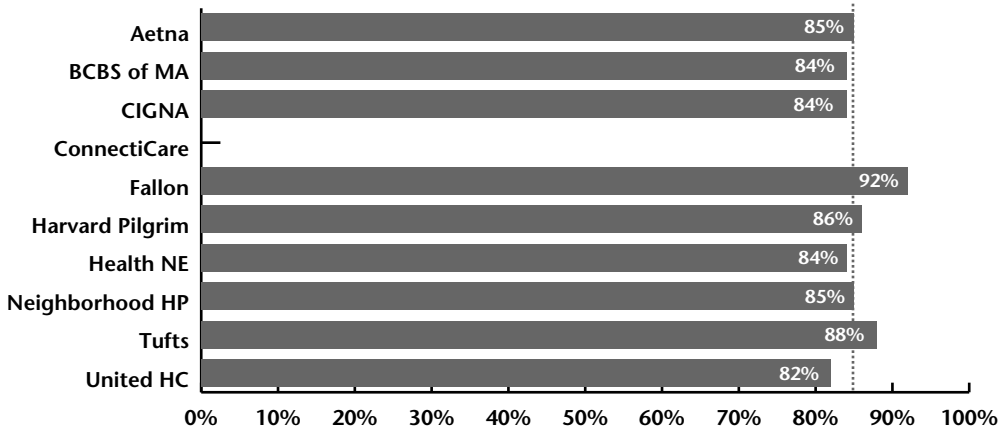
Mental and Behavioral Health

Figure 22: Good Antidepressant Medication Management – 6 Months



Antidepressants are most effective in keeping periods of depression from happening again when they are taken for 4 to 9 months after the patient is diagnosed with depression.[41] Figure 22 shows the percentage of patients who were treated with antidepressant medication and continued their medication for at least six months after being diagnosed with depression.

Figure 23: Follow-up after Hospitalization for Mental Illness



Getting care and therapy after being hospitalized for mental illness "is important for recovery."[42] Figure 23 shows the percentage of members age 6 and older who were hospitalized for mental illness and were seen by a mental health provider within 30 days after leaving the hospital.

Plan Members' Satisfaction Ratings

This section provides you with information collected from a sample of health plan members who were surveyed about the performance of their health plans. As with the previous sections, a higher percentage indicates better performance, in this case, from the perspective of the people who were surveyed.

Member Satisfaction Survey

Health Plan	Percent of Members for whom getting needed care was not a problem.	Percent of Members who, when needing care right away, were usually able to get care the same day.	Percent of Members who reported that their health plan always or usually handled claims correctly and in a reasonable amount of time.
Aetna	77%	53%	84%
BC/BS of MA	83%	59%	94%
CIGNA	78%	57%	79%
ConnectiCare	82%	61%	94%
Fallon	82%	67%	88%
Harvard Pilgrim	86%	65%	93%
Health NE	86%	57%	96%
Neighborhood HP	78%	63%	NA
Tufts	82%	65%	94%
UnitedHealthcare	80%	63%	82%

Plan Members' Satisfaction Ratings

Percent of Members who reported that it was not a problem getting help from their plan's customer service.	Percent of Members who felt that their health plan always or usually clearly states the amount of money that members would have to pay.	Percent of Members who did not call or write to their health plan with a problem in the past year.	Percent of Members who rated their health plan a 9 or 10 (0 being worst and 10 being the best).
68%	70%	86%	29%
79%	82%	89%	39%
66%	71%	78%	31%
76%	81%	88%	39%
78%	77%	89%	38%
81%	79%	89%	65%
80%	82%	91%	45%
70%	65%	85%	45%
79%	79%	88%	50%
60%	75%	85%	34%

Appeals and Complaints

There may be times when you are unhappy with your health plan and the decisions they make about your care. In Massachusetts there are various government agencies that will help you appeal a health plan decision or file a complaint against your plan.

It is important to note that the help available to you depends on your health insurance plan.

If Your Health Plan Is Self-funded…

In a self-funded plan, the plan sponsor (usually an employer or union) takes responsibility for paying all of the claims incurred by the employees or union members. These plans are sometimes referred to as "ERISA" plans and are not subject to state insurance requirements.

Rather than paying premiums to an insurance carrier, the plan sponsor hires a third party administrator (TPA) to process claims, establish a provider network, and provide customer service. Sometimes, the TPA is part of an insurer's or an HMO's organization, and the ID card issued to the employee/member carries its name. This is why members of these plans may be unaware that their plan is self-insured.

An organization that sponsors an ERISA self-funded plan must give participants and beneficiaries a summary plan description (SPD) that clearly describes their rights, benefits, and responsibilities. The SPD also must list the names of the fiduciaries. Fiduciaries are the people who have control over the assets of a plan, including its operations, which include claims payments. Your plan may have several named fiduciaries. One fiduciary may be responsible for paying claims while another is responsible for reviewing appeals of claims denials.

If you want to file an appeal, you have a specified amount of time to do so and the plan must respond within specific time frames, which are defined by the U.S. Department of Labor (DOL). You should also know who the fiduciary is in the event that you leave your job and have concerns about continuing coverage. Most beneficiaries are entitled to continue coverage if employment is terminated. Plans are required to offer beneficiaries, at their own expense, the right to maintain comparable health care coverage at a comparable cost.

If you have further questions please call (866) 444-3272 or visit the U.S. DOL website at: www.dol.gov/ebsa.

Additionally, although it has no legal authority to enforce federal law, the ombudsman's office within the Office of Patient Protection (OPP) is authorized to assist Massachusetts residents in "ERISA Plans" who want help in understanding the claims review process they have available to them.

If Your Health Plan Is Fully Insured…

The Office of Patient Protection (OPP) is part of the Massachusetts Department of Public Health (DPH). The OPP staff is available to assist you with questions and concerns regarding managed care grievances, appeals, denials of care, continuity of care, and independent external reviews.

Appeals and Complaints

The OPP helps consumers by:

- Investigating problems that may arise with your health plan, and often working out a satisfactory resolution;
- Assisting you in understanding your benefits, the health plan internal grievance process, and the external review process; and
- Administering the external review process.

If you are an insurer, health plan administrator, or consumer and have questions, please contact the OPP at (800) 436-7757 or visit their website at: www.mass.gov/dph/opp.

How Do I File an Internal Grievance?

Every Massachusetts-regulated health plan must have a formal internal grievance process to respond to members' concerns and issues. The grievance process is generally included in the summary plan description. If you disagree with a decision made by your health insurance carrier, you may appeal to the carrier for review.

For example, if your health plan refuses to pay for treatment that you believe you need, or if it notifies you that it will stop providing or paying for treatment, you can request that the decision be reviewed. Each health plan company must describe how you can appeal a decision in its certificate/booklet or summary of plan benefits.

If you choose to appeal a decision, *do not* delay completing the paperwork or making the phone call; appeals, unlike grievances, do not have to be in writing. Most plans have a relatively short time during which you must appeal in order to preserve your appeal rights. When you begin the process of appealing a decision, you should keep written records of everything you do and everyone with whom you speak.

Under Massachusetts law, a fully insured plan must respond to your appeal in writing within 30 business days of receiving your appeal. There is also a process for expediting an appeal when the request involves an inpatient, terminally ill member, or the service is urgently needed to preserve the health of the member.

If you have appealed your plan's denial of medical necessity through an internal grievance process and that decision is upheld, you may request an external review from the OPP within 45 days of receiving notice from the health plan of its final decision ("final adverse determination"). The health plan must send you a form and information on how to file an external appeal. There is also a process for filing an expedited review and for requesting that coverage continue while the external appeal is pending.

You may also get an external review form from the OPP at www.mass.gov/dph/opp or by calling (800) 436-7757. The completed form should be sent to the OPP with a check for $25.00 and your consent to release your medical information. If you cannot afford the $25.00 fee, you can request that the fee be waived. If you are unsure if your appeal is eligible for external review, you may contact the OPP for additional assistance.

Standard appeals must be resolved within 60 business days. Expedited appeals must be decided within 5 business days.

Appeals and Complaints

Please remember that the decision by the external review panel is final and binding. Please visit the OPP website (www.mass.gov/dph/opp) for helpful answers to frequently asked questions about the external review process.

If Your Plan Is a Fully-Insured Fee-for-Service Plan Not Subject to Managed Care Regulation…

Even though fee-for-service (or indemnity) plans may have certain features that are "borrowed" or similar to managed care practices, not all are subject to OPP oversight.

If you have any questions or concerns with decisions made by your non-regulated indemnity plan *and* you are the policyholder for that plan, please contact the Massachusetts Division of Insurance's Consumer Service at (617) 521-7777.

If your employer or union is the policyholder, you should contact them with your questions. The policyholders are responsible for writing to the Division of Insurance on your behalf.

If Your Plan Is a MassHealth (or Medicaid) Plan…

Please direct your questions and concerns with MassHealth/Medicaid to the MassHealth Customer Service Center at (800) 841-2900. Appeals and complaints for MassHealth plans are heard by the Board of Hearings, which can be reached at (800) 655-0338.

Additional information for MassHealth can be found on their website at: www.mass.gov/masshealth.

If Your Plan Is a Medicare Plan…

Please direct your Medicare questions and concerns to the Medicare Customer Service line at 1-800-MEDICARE. Information on Medicare appeals can be found on the Medicare website at: www.medicare.gov/basics/appeals.asp.

Government Employees…

See "Information for Non-Commercial Plan Holders" in the following section ("Additional Resources").

Additional Resources

For Accreditation and Reports

- The Board of Registration offers a comprehensive look at over 27,000 physicians licensed to practice medicine in Massachusetts. Call (800) 377-0550 or visit www.massmedboard.org.
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the national accrediting body for hospitals. Call (630) 792-5000 or visit www.jcaho.org.
- The Massachusetts Department of Public Health, Division of Health Care Quality, which is the licensing authority for hospitals in this state. Call (617) 753-8000 or visit www.mass.gov/dph/dhcq.
- The Division of Health Care Finance and Policy has information on both quality and cost of care at hospitals. Visit www.mass.gov/healthcareqc.
- The Massachusetts Health Quality Partners (MHQP) is a coalition of health care providers, plans and purchasers working together to improve health care quality in Massachusetts. Call (617) 972-9079 or visit www.mhqp.org.

For Other Benchmarks and Comparisons

- For health plan information from NCQA's HEDIS measures, please visit www.ncqa.org.
- For health plan information from the National CAHPS Benchmarking Database (NCBD), please visit www.ncbd.cahps.org.
- For information on companies accredited by URAC, please visit www.urac.org.

Information for Non-Commercial Plan Holders

- For most state employees, please contact the Group Insurance Commission. Call (617) 727-2310 or visit www.mass.gov/gic.
- For users of self-funded/ERISA plans, please call the Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or visit www.dol.gov/ebsa.
- For most federal employees, contact your human resource office.

For Information on Medicare, Medicare-HMOs (Managed Care), and Medicare Part D (The New Pharmacy Benefit)

- For health insurance counseling services for the elderly, please contact SHINE (Serving the Health Information Needs of Elderly) within the Massachusetts Executive Office of Elder Affairs. Call 800-AGE-INFO (800-243-4636) or visit www.800ageinfo.com.
- For general information about Medicare from the Federal government, call (800) MEDICARE or visit www.medicare.gov.

For Information on MassHealth/Medicaid

- For general information on MassHealth/Medicaid, please call (800) 841-2900 or visit www.mass.gov/masshealth.

For Information on Tax-Favored Health Accounts

- For general information on health savings accounts, medical savings accounts, flexible spending arrangements, and health reimbursement arrangements, please call (800) 876-1715 or visit www.irs.gov.

Additional Resources

Other Important Resources

The Office of Patient Protection (OPP)

The OPP within the State's Department of Public Health (DPH) was created to help protect the rights of Massachusetts consumers and other individuals who receive health coverage from a Massachusetts carrier, insurer, or HMO. These new protections cover internal grievances, medical necessity guidelines, continuity of care and independent external reviews.[43]

If you are a managed care plan carrier, insurer, or consumer, and have questions concerning the new legislation or regulations, please contact the OPP at (800) 436-7757 or visit www.mass.gov/dph/opp.

Bureau of Managed Care

The Bureau of Managed Care within the State's Division of Insurance accredits managed care plan carriers in Massachusetts to make sure that they are in compliance with Massachusetts laws. The Bureau sets minimum standards for utilization review, quality management and improvement, credentialing, preventive health services, provider contacts, and consumer disclosures. The Bureau also investigates complaints against carriers for noncompliance with accreditation requirements.[44]

If you believe a carrier has not complied with statutory requirements, please contact the Bureau at (617) 521-7372. You can find more information about the Bureau at www.mass.gov/doi/Managed_Care/managed_care_home.html.

Massachusetts Division of Insurance

There are many insurance coverage products to purchase in the Commonwealth of Massachusetts. Prior to purchasing any insurance coverage, consider contacting the Massachusetts Division of Insurance at (617) 521-7777 or visit their website at www.mass.gov/doi for consumer guides and up-to-date information on approved health insurance coverage products.

Massachusetts Division of Insurance offer the following tips on insurance purchases:[45]

- Schedule a routine "check-up" with your agents or insurers at least once a year to ensure that you have adequate coverage for all policies.
- Inquire about the cost benefit of opting for higher deductibles.
- Ask specifically about available discounts.
- Where competitive rating is permitted, shop around among insurers for the coverage you need at the best price.
- Remember that an insurance policy is a legal document. Read it carefully.

Glossary

CAHPS 3.0H Survey[46]

Stands for "Consumer Assessment of Health Plan Survey." The CAHPS 3.0H survey is conducted every year and asks health plan members various questions regarding their satisfaction with a variety of aspects of their health plans. Member satisfaction data presented by the NCQA Quality Compass® database is gathered using the CAHPS 3.0H survey.

COBRA (Consolidated Omnibus Reconciliation Act)[47]

A federal law enacted in 1986 that gives qualifying employees who lose their health insurance under certain circumstances the right to continue their insurance coverage under group insurance rates for at least 18 months. Employees covered under COBRA must pay their entire insurance premium, up to 102% of the plan cost. Continuing an employer's health insurance through COBRA may cost less and/or provide better coverage than purchasing a health insurance policy in the non-group market.

Coinsurance

The percent of costs for health care services that a health plan member must pay. For example, if your health plan covers 80% of a doctor's visit, then you must pay 20% coinsurance on the bill. The amount you must pay increases as your medical bill increases.

Copayment

An arrangement with a health plan in which you pay a fixed amount of money out of your own pocket for using various health care resources. For example, you may be required to pay a $15 copayment for a visit to your doctor.

Deductible

An amount that a health plan may require you to pay for health care expenses before any health insurance coverage or discounts starts to apply. For example, if a health plan has a $100 deductible, you must pay $100 in health care expenses before your health plan will contribute.

ERISA (Employee Retirement Income Security Act)

A federal law enacted in 1974 that "sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans."[48] The Act allows self-funded plans (also defined in this glossary) to avoid "paying premium taxes, complying with state-mandated benefits, or otherwise complying with state laws and regulations regarding insurance…"[49]

Fully-insured Plan (or Fully-funded Plan)

A health insurance plan where the insurance company or managed care plan carrier pays for the medical costs of its members.[50] Unlike a self-funded plan (also defined in this glossary), the premiums paid by fully-insured plan members go into a pool of money that is owned by the insurance company or managed care plan carrier, which in turn, bears the risk of its members' medical costs. Fully-insured plans also have to abide by all state insurance regulations.

HDHP (High Deductible Health Plan)

Health plans with a higher deductible than that of most other health plans. For 2006, the minimum deductible amount for an individual HDHP is $1,050 and $2,100 for a family plan.[51] People who have health savings accounts must receive health insurance through a HDHP. The 2006 maximum limit for out-of-pocket expenses is $5,250 for individual coverage and $10,500 for family coverage.

Glossary

HEDIS® (Health Plan Employer Data and Information Set)[52]
A survey tool developed by the NCQA to measure health plan performance, not member satisfaction with their health plans (member satisfaction is measured with the CAHPS 3.0H survey, also defined in this glossary). The survey collects over 60 different measurements, including immunization status, breast cancer screening, controlling high blood pressure, etc.

In-network Provider
All heath care providers, including doctors, nurses, specialists, pharmacists, etc. who participate in a network of care set up by a health plan. In-network providers have contracts with the health plan to provide medical care to the health plan's members at a discounted price.

Massachusetts Bureau of Managed Care
The Bureau of Managed Care operates under the Massachusetts Division of Insurance (also defined in this glossary). The Bureau accredits health plans to make sure that they are in compliance with the State's laws; sets minimum standards for "utilization review, quality management and improvement, credentialing, provider contracts, and consumer disclosures;"[53] and investigates claims of noncompliance.[54]

Massachusetts Division of Insurance (DOI)
A state agency that aims to protect Massachusetts consumers of various types of insurance. The DOI tries to "promote a healthy, responsive and willing marketplace for consumers who purchase insurance products" by "providing accurate and unbiased information so consumers may make informed decisions[,]… and intervening on behalf of consumers who believe they have been victimized by unfair business practices."[55]

Massachusetts Office of Patient Protection (OPP)
Operates as part of the State's Department of Public Health. The OPP "is responsible for assisting consumers with questions regarding managed care and administering the process by which consumers may apply for external review for a benefit denial by a managed care organization."[56]

NCQA (National Committee for Quality Assurance)[57]
The NCQA is a nonprofit organization with a mission "to improve the quality of health care" through "measurement, transparency and accountability."[58] The NCQA accredits managed care organizations based on standards that they have developed. The organization also develops the HEDIS® survey tool to measure performance of health plans, and maintains the Quality Compass® database where employers, researchers, health plans, etc. can access the collected performance measurements.

Out-of-network Provider
All health care providers, including doctors, nurses, specialists, pharmacists, etc. who do not participate in a network of care set up by a health plan. Because there are no contracts between out-of-network providers and the health plan, getting medical care from them is likely to be more expensive than care provided by in-network providers (also defined in this glossary).

Out-of-pocket Expense
Any money that you pay for medical care. These expenses include the money you may pay in copayments, coinsurance, or deductibles (also defined in this glossary) for getting care.

Glossary

Primary Care Physician (PCP)

Doctors who manage and coordinate a health plan member's medical needs. PCPs are usually doctors who practice general medicine, including internists, pediatricians, family physicians, general practitioners, and occasionally, obstetricians/ gynecologists.[59] Depending on the nature of the health plan, members may be required to see their PCP to get a referral to higher-level care provided by a specialist (also defined in this glossary).

Self-funded Plan

A health plan where the money used to pay for its members' medical costs comes from the organization offering the plan, (usually an employer or union), and not from an insurance company or a managed care plan carrier.[60] Unlike a fully-insured plan (also defined in this glossary), the premiums paid by self-funded plan members go into a pool of money that is owned by the organization that offers them the health plan. The organization, not any health insurance carrier, bears the risk of its members' medical costs. Self-funded plans may hire insurance companies or managed care plans to provide administrative support for delivering benefits; for example, issuing health plan cards, filing paperwork, etc. Self-funded plans are exempt from state insurance regulations but must abide by federal employee health benefit plan regulations.

Specialist

Doctors who treat specific parts of the body or specific diseases. Specialists usually do not function as primary care physicians (also defined in this glossary). Cardiologists, surgeons, radiologists, oncologists, and nephrologists are all examples of specialists.

Summary Plan Description (SPD)

A document that health plan members receive every year that tells them how their plan works and what benefits are available under the plan. Information provided includes "when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits become vested, when and in what form benefits are paid, and how to file a claim for benefits."[61]

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Production

This guide was researched and produced by the staff of the Division of Health Care Finance and Policy, a state agency under the Executive Office of Health and Human Services.

Consumer Guide Comments

This consumer guide has been produced to help answer your questions about managed care. The guide will be updated. Please let us know how you think the guide could be improved to be more useful to you. If there is additional information that you would like to see in the guide, please let us know by sending an email to: harry.lohr@state.ma.us or by writing to the following address: Consumer Guide, Division of Health Care Finance and Policy, Two Boylston Street, Boston, Massachusetts 02116.

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